community interests. For instance, in the series reported by Webb and colleagues,[4] 72% had coronary artery disease. No data describe how these patients have been managed. Furthermore, a long series of exclusion criteria precluded the percutaneous aortic valve implantation in this and other series,[3,4] although the implantation of a percutaneous prosthesis is initially considered in patients with absolute surgical contraindications. Nevertheless, in the experience reported by Webb and associates,[4] a patient had been successfully converted to surgery. By using epidural anesthesia, my colleagues and I[2] did not add any cost, and we greatly reduced the need for intensive care unit management. On the other hand, considering that the percutaneous prostheses are sold at a cost 10-fold higher than a standard bioprostheses, and considering the early 30-day results of percutaneous implantation,[1,3,4] we maintain that surgery at the moment is to be preferred over a percutaneous approach. On the contrary, we believe that currently there are no factors that might preclude surgery for any patient. Instead of finding a way to replace surgical therapy, percutaneous approaches should be used as an adjunct to surgery, to support it in its current limitations, such as being used to replace deteriorating bioprostheses and avoiding the complications related to repeated heart dissections.[5]

Tomaso Bottio, MD, PhD
Cardiovascular Institute
University of Padua Medical School
Padua, Italy

References

1. Marcheix B, Lamarche Y, Berry C, Asgar A, Laborde JC, et al. Surgical aspects of endovascular retrograde implantation of the aortic CoreValve bioprosthesis in high-risk older patients with severe symptomatic aortic stenosis. *J Thorac Cardiovasc Surg*. 2007;134:1150-6.
2. Bottio T, Bisleri G, Piccoli P, Negri A, Manzato A, Muneretto C. Heart valve surgery in a very high risk population: a preliminary experience in awake patients. *J Heart Valve Dis*. 2007;16:187-94.
3. Grube E, Schuler G, Buellesfeld L, Gerckens U, Linke A, Wenaweser P, et al. Percutaneous aortic valve replacement for severe aortic stenosis in high risk patients using the second and current third generation self expanding CoreValve prosthesis. *J Am Coll Cardiol*. 2007;50:69-76.
4. Webb JG, Pasupati S, Humphries K, Thompson C, Altwegg L, Moss R, et al. Percutaneous transarterial aortic valve replacement in selected high-risk patients with aortic stenosis. *Circulation*. 2007;116:755-63.
5. Zegdi R, Khabbaz Z, Borenstein N, Fabiani JN. A repositionable valved stent for endovascular treatment of deteriorated bioprostheses. *J Am Coll Cardiol*. 2006;48:1365-8.

doi:10.1016/j.jtcvs.2007.11.063

Notice of Correction

Nia AE, Amirghotran AA. Complete occlusion of the left main coronary artery ostium in Takayasu arteritis. *J Thorac Cardiovasc Surg*. 2008;135:695-6.

The first author's name was listed incorrectly. The correct name is Abbas Emaminia.

Notice of Correction

Maselli D, De Paulis R, Weltert L, Salica A, Scaffa R, Bellisario A, Mingiano A. A new method for artificial chordae length "tuning" in mitral valve repair: Preliminary experience. *J Thorac Cardiovasc Surg*. 2007;134:454-9.

The following two authors were inadvertently admitted from the author line of this article: Simona Celi, MSE, PhD, and Francesca Di Puccio, MSE, PhD.